TriPoint Acupuncture

Name: _____ Phc( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Sex: _____ DOB: _____ Email: _____

Would you like to receive my newsletter when available? ☐ Yes ☐ No

Incase of emergency, please contact:

Name: _____ Phc( ) _____

Relationship: _____

Please take a moment to describe the history of your current condition: _____

_____

_____

Name and location of your primary care provider: _____

Date of most recent visit: _____

Other medical history and surgeries: _____

_____

Pertinent family medical history (Heart disease, diabetes, etc.): _____

_____

☐ Yes ☐ No Any injuries in the past two years?

☐ Yes ☐ No Are you pregnant?
If yes, please see the other side of this form.

☐ Yes ☐ No Do you suffer from joint swelling or arthritis?

☐ Yes ☐ No Do you faint easily or have a bleeding disorder?

☐ Yes ☐ No I understand that there is a 24-hour cancellation policy.

☐ Yes ☐ No Do you have any allergies?
If so, please specify:

☐ Yes ☐ No Do you have tension or soreness in a specific area? If so, please specify:

☐ Yes ☐ No Please list any current medicatons you are taking and any other pertinent information:

_____
Signature

_____
Date

If you are pregnant please read the following:

I certify that I am receiving medical care and management of my pregnancy. I understand that the acupuncture treatments I am seeking are to help me with health issues related to my pregnancy and are not intended to manage the pregnancy, affect my unborn child, or induce labor.

By signing below I have read and understand the statement above.

_____ _____

Signature Date